



**COLORADO PSYCHIATRY  
CENTER**

## Joint Medical Decision Making Rights

I am the divorced parent of the patient \_\_\_\_\_.  
Print Patient's Name

I give my ex-spouse \_\_\_\_\_ permission to make medical decisions  
Ex-Spouse's Name

on my child's behalf while receiving care at the Colorado Psychiatry Center when I am not present.

\_\_\_\_\_  
Parent Signature Date

I understand that we must manage appointment times and treatment to make joint medical decisions on the behalf of our child \_\_\_\_\_ . I understand that

[Patient's name]

Colorado Psychiatry Center will not serve as mediators of any discrepancies of treatment or appointments. I also understand that if we as the parents of the patient are unable to come to an agreement on the child's care, Colorado Psychiatry Center will discharge my child from the practice until the treatment plan is resolved by both parties.

This form may not be altered. If this form is signed, the parent or guardian is agreeing to the original form in its entirety.

\_\_\_\_\_  
Guardian Signature Date

\_\_\_\_\_  
Guardian Signature Date